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into a target population's health-related beliefs and practices. For example, a health communication scholar who is developing a campaign to promote exercise may ask a participant why nobody is using a running trail in a local park. Interviews are also a valuable tool for evaluating a health campaign that has already been disseminated to a particular audience. In this case, interviewers may ask participants to describe their reaction to antismoking commercials broadcasted as part of a message-based health campaign.

Health communication scholars may also use interviews to gain insight into the health experiences of patients, providers, and family members and/or develop health communication theory. In particular, interviews can be a valuable tool for learning about participants' experiences with sensitive topics, which are frequently of interest to health communication scholars. For example, interviews may focus on a family member's final conversation with a loved one under hospice care or a provider's experience breaking bad news to a patient. One of the benefits of research interviews is learning about health experiences without encroaching on these deeply personal events.

Although they vary in their form and purpose, medical and research interviews are both important to the field of health communication. Medical interviews are vital to the diagnostic and therapeutic features of clinical health care as well as a primary context for health communication scholarship. Research interviews provide insight into individuals' health-related experiences, beliefs, and actions, which is integral to health communication theory and practice.

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See Also: Doctor–Patient Communication; Evaluation: Qualitative Methods; Patient and Relationship-Centered Communication and Medicine.

Further Readings

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Lindlof, Thomas R. and Brian C. Taylor. *Qualitative Communication Research Methods.* 3rd ed. Thousand Oaks, CA: Sage, 2011.

Invisible Disabilities

According to the 2002 U.S. Census Bureau, approximately 96 percent of individuals with a disability or illness live with one that is invisible. An invisible disability is defined as one that is unseen, hidden, concealed, or not immediately apparent so as to not be instantly observed by another, excluding under infrequent circumstances or by disclosure from persons. Invisible disabilities (IDs) such as anxiety disorders, attention deficits, autism spectrum disorders, bipolar disorder, depression, epilepsy, learning disabilities, HIV/AIDS, pain, psychiatric impairments, schizophrenia, seizure conditions, and Tourette's syndrome are not easily noticed. IDs can also include chronic illnesses and conditions such as diabetes, epilepsy, chronic fatigue syndrome, fibromyalgia, and sleep disorders if the condition significantly impacts daily life activities. As the number of individuals with IDs increases, the need for better understanding of communicative behaviors and IDs' impact on health also increases.

The impact of IDs is varied, as they can affect a person's efforts in school, work, and/or socializing. An ID may create difficulties for the person because it is hard for others to recognize or acknowledge it if they cannot see it in a visible way. Often IDs are visible in some situations and invisible in others due to context or environment. Some individuals may choose not to disclose an ID with an employer or professor because of the stigma that surrounds IDs.

Health communication scholars have researched the stigma faced by individuals with IDs. Some examples of stigma experienced by people with IDs are attitudinal barriers such as being treated as "other" or missing out on education and job opportunities, as well as friends or partners. Similar to other minority groups,

individuals with IDs are a stigmatized minority and experience shame. People with IDs are often put in the difficult position of having to convince people that they really have a disability and are not taking advantage of accommodations or unnecessarily complaining. Some people chose not to disclose their IDs, which can lead to the tension of having to hide a disability. Because of the stigma and shame, individuals with IDs rely on impression management, uncertainty reduction, and selective self-disclosure as important communication skills. Often individuals with IDs are able to "pass" or conceal the disability.

There are two contrasting models or ideologies that frame how people with IDs are treated and viewed: the medical and social models. These models help health communication scholars understand or frame the stigmatization individuals with IDs face. The medical model positions disability as a physical or mental impairment of the individual, with personal and social consequences. Also, within the medical model there is a belief that the biological condition can be corrected, "cured," or overcome. This perpetuates the idea that the person with a disability is "abnormal." Health care professions who adopt the medical model may undervalue or discount the social and environmental obstacles faced by persons with disabilities.

On the other hand, the social model emphasizes the relationship between an individual and his or her social environment. In this model, discrimination is expressed in public life (e.g., work, education, policies). In Western society, independence and productivity are valued. Because of the demands of social life, a person with physical or mental disabilities may be excluded and segregated through restricted access to certain environments and social activities. The Americans with Disabilities Act of 1990 and the Rehabilitation Act of 1973 are national laws that protect people with visible and invisible disabilities.

Most research in health communication focuses on those with visible disabilities. However, health communication scholars examine IDs in the media, labeling and stigma, health care for people with IDs, intersections of identity social relationships, and social support. Research centers on topics across the communication discipline, including relationship issues, organization and cultural communication, and media and technology as they impact specific types of IDs. In health care, studies report communication issues between patients with IDs and their providers or family members. However, most of these studies do not address the impact of disability on communication. For example, an individual with an ID may not express his or her experience of shame with a physician because of American cultural taboos around shame. Additionally, medical curricula do not generally teach doctors how to reduce shame responses. The goal of health communication scholarship is to help individuals with and without invisible disabilities advance communication and relationships.

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See Also: Disabilities and Family Relationships; Disability; Media Depictions: Disability; Social Construction: Disability; Stigmatization; Stigmatization, Consequences of; Stigmatization, Coping With; Support Providers and Persons With Disabilities, Decision Making Between.

Further Readings
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Iran

The Islamic Republic of Iran is the second-largest nation in the Middle East and the 17th-most populous in the world, with 77 million people in about 636,000 square miles. The mountainous